UTAH DIGITAL HEALTH SERVICE COMMISSION MEETING

Thursday January 6, 2022, 10:00 AM – 12:00 PM MT
Room 101 (Cannon Building) & Google Meet (meet.google.com/wwk-nixj-mkd)

Draft Minutes

Members Present: Preston Marx, Chris Klomp, Dallas Moore, Randall Rupper, Banjamin Hiatt, Seraphine Kapsandoy Jones, Todd Bailey*, Matthew McCullough*

> **Todd and Matthew did not count towards a quorum of commissioners as the senate had not yet confirmed their reappointments to the commission.*

Additional Attendees: David Cook, Deepthi Rajeev, Huaizhong Pan, Humaira Lewon, Kyle Lunt, Robert Wilson, Sid Thornton, Holli Mills, Mark Fotheringham, Christopher Bramwell, Debbie Williams, George McEwan, John Wadsworth, Rich Saunders

Welcome and Motion

Kyle Lunt mentions that Todd and Matt won't count towards 7 members due to a delay in the Senate reappointing them. Mentions that some voting will have to wait until the March meeting.

Preston Marx introduces himself. VP of Strategy at Uintah Basin Health Care. Says any topics of interest for future meetings should be sent towards him. Preston asked if there was anything that needed to be brought up that wasn't on the agenda. No response given.

Updates on State Innovation Projects

Richard Saunders introduces himself as Chief Innovation Officer under Governor Cox. He says that is a new position in the state. He says he works with Governor's administration to improve state government. He was previously executive director at the Department of Health.

Richard Saunders gives update on Utah Citizen Portal. It is focused on streamlining state government. It is aiming to be a customer centric experience. It allows various parties to access government services through single source and secure login environment. The goals include reducing lines and wait times at state offices, giving citizens control over what state can do with information on them, saving time and money for citizens, improving environment by reducing trips to state offices, reduction in cost to deliver state services, and allowing citizens to access services at any time and place.

Preston Marx asked how the state of Utah compares to other states. Richard Saunders said that the short answer is that Utah is a leader in the nation. George McEwan is I.T. director for the Department of Health. The Citizen Portal was built from legislation. It was originally called Business Portal and went live in 2021. The governor's 2023 budget proposes $29 Million for the project. There are a few states that have started doing similar things. The plan for the Utah Citizen Portal includes things not found in other systems. Functionality includes identify management and master patient index. One goal is to have a website service that is easy to navigate. For some tasks the Citizen Portal may direct users to another portal. One advantage of the portal is that you won't have to manually enter identifying information into so many places. George McEwan turns time over to Christopher Bramwell to discuss security.

Christopher Bramwell introduces himself as appointed and confirmed government operations privacy officer. His job is to make recommendations for changes to privacy policy changes in the state of Utah. This includes all policies relating to Citizen PII data. Along with his position a personal privacy oversight commission was also created. When being considered for his position, he had a vision for how privacy would be implemented in the citizen portal. His vision involved allowing citizens to track how their data was used. This can create accountability for the state regarding how they comply with privacy laws. The long-term goals include providing citizens with accurate reports on where their data is used across government, how it is being used, who it is being used with, and when it will be destroyed. Another goal is to provide standardized data collection for compliance with GRAMA. Another goal to develop an automated system to notify citizens of data breaches.

The vision includes citizens being able to log into a website to see a summary of entities that have data on them and what data.

Question from Henry Gardner. The 2009 HITECH Act designated state to oversee exchange of patient data. That responsibility was given to UHIN. Does this system give that responsibilities to UHIN.

George McEwan says that to some degree it will. The goal is to take the cap off of different agencies.

Question from Chris Klomp. UHIN works with the government but it is technically not a government agency. Some of this data would also be shared with private sector entities. Are you planning to expose access to SSO identification tool?

George McEwan. The answer is yes. There is a community information exchange with funding to work with nonprofit NGO's to help people receive services. The service will allow people to

decide to share information with various entities. The users won't have to be an expert in what various services.

Christopher Bramwell. UHIN changed their NPI provider to NextGate. There have been discussions on the possibilities of common NPI providers and being able to implement those future features.

Question from David Cook from Comagine Health. Will citizens of Utah be able to pull up their immunization records. George McEwan says that is mentioned in the statute as a service to bring online.

Question from John Wadsworth. Are there things that the private sector can do that create value for this work. George McEwan says the first small nudge is open conversations about these possibilities. These conversations can help educate the legislature.

Chris Klomp. There are a lot of people in Utah who don't have consistent internet access. This won't be very useful for them. A disproportionate fraction of patients won't be able to be served by these technologies. George McEwan says they are going for mobile first approach. For 75% of the Medicaid community, the smartphone if primary computing device for the household.

Question from Ben. State partitioning is rolling out. It is expected to break a lot of existing single sign on applications. Storage for domains is isolated. Is the first version being built for these challenges or would that be for the second version. George McEwan says they are trying to build that into the first version. They are not going to unified identity on existing identity management stack that the state currently has.

Health care costs in Utah and everywhere else have been rising and inequities have been compounding. It's easy to focus on treatment more than prevention. These rising costs will stung Utah's economic growth. Utah is number 4 in the nation for rising health care costs. They need to bring forth professionals and communities that haven't generally worked together. A new health collaborative has been created to help solve these challenges. The collaborative will not be owned by the state. It will be independently managed and serve four functions.

1. It will serve as a convener.
2. It will be a site for innovation.
3. It will support providers to make changes they need to make. Caregivers feel they aren't able to spend a lot of time with their patients.
4. They will recommend policy and infrastructure changes.

The goal is to have this collaborative modeled out and recommended in either January or February. It can't be corrupted by politics or its source of money. It is bigger than a think tank and is more of a work shop type environment. Projects that the collaborative might take on include integration of behavior and physical health, initiative addressing social determinants of health, pharmacy efforts, expansion of successful opioid related efforts, increased care coordination for patients in rural areas. The goal is to have the collaborative functioning by June of this year. Partner involved include Intermountain Healthcare, University of Utah Healthcare, HCA, Steward Health, and the Utah Hospital Association.

Richard Saunders said that this collaborative is trying to counteract a negative trajectory. The efforts that failed in the past have been top down heavy hammered forced approach. The next effort will try to bring solutions to the health systems. Adapting proposed solutions will be optional. Preston said that from the standpoint of health systems it is better for initiatives to be done with them rather than to them.

Chris Klomp asked about data support component, and there will be a budget and administrative and analytical support. Richard Saunders said there is a budget request for $650,000 to set infrastructure up and more money allocated to keep it going.

John Wadsworth asked if any other state was trying to do something similar. Richard Saunders replied that some states are trying similar things and that the nation is likely going to move in this direction.

When you see value-based care it often puts pressure on the physician to click one more box or add one more data element. EHR's sometimes make it difficult to find those boxes. It would be good to include practitioners in the commission. To keep practitioners in the exam room they have to hire other staff to contact patients and do other administrative work.

Commission Member Spotlight

Chris Klomp. Chris Klomp was born in Gainsville Florida when his dad was doing his residency. When he was 2 he moved to Boise where he was raised. His wife was also raised in Idaho. He attended 1 year of BYU from 1998-1999. After that served as a Latter-Day Saint missionary in Romania for two years. (1999-2001) After than he finished his education at BYU from 2001-2004. He then worked at Bain & Company. He had worked for them as an intern while at BYU. His original major at BYU was in Microbiology with the intent to be a physician. His mother died from cancer. Likely due to medical errors which he always thought was frustrating. During his time in Romania, he met someone who told him he could help the health care system from the management side. After that he went to BainCapital. He did graduate work at Stanford and then returned to BainCapital. He had a friend from college and growing up whose mom was a social worker and had worked with people affected by Opioids. Some of his friends came up with a computer program to help automate her work. They did not have success with selling their

program. Eventually a hospital decided to buy it and then CollectiveMedical was born. They now serve about one third of hospitals in the country. Eventually CollectiveMedical was acquired by PointClickCare in 2021.

PointClickCare focuses on lots of vulnerable patients. They are also focused on senior patients. It's the electronic medical record for about 70% of skilled nursing facilities and 50% of assisted living facilities in the United States. It has a SaaS infrastructure meant to drive down costs and improving clinical outcomes. Their focus is to drive insights at where decisions are being made. Their company has access to real time data. They aiming to help care providers know critical information for patients who come into their emergency room. Their work boils down to Data aggregation, Data manipulation/Insight generation, and Insight Sharing. An example of their work is High ED Utilization, helping people avoid going to the emergency room when unnecessary. This includes analyzing different visits that an individual has made to different places.

ReadiHealth Working with Office of Primary Care

Holli Mill's group found John and his colleague Jeff at ReadiHealth Analytics last year. They were trying to find someone who could help perform a population health needs assessment for independent rural hospitals for the state. They knew a lot about rural health. John has masters in Bio Medical Informatics and about 20 years of experience with health data analytics including time at Intermountain Healthcare and Health Catalyst.

John Wadsworth. There is a large disparity between the top 100 health systems who have resources to create robust analytics and other systems not in the top 100. They are trying to help community leaders take action on data and build high-tech careers in rural communities. The benefits derived from the 100 systems come from analytics expertise, the application of expertise, and data literacy. The small systems lack analytics expertise. A challenge in the rural health systems is that if workers learn these skills, they can often make much more money in a more urban area. Another challenge is that in addition to having the expertise you also need to have deep knowledge of healthcare data and how the data can add value in different ways.

They spoke to 9 rural health facilities who said they weren't interested in adopting value-based care. It was very difficult to answer questions about the health of the communities such as who the diabetics are or who has heart failure. They went to the 9 facilities and offered to provide an analytics ecosystem overview and help them understand their technology capabilities better. The components of the project were to study the capabilities, analyze that information, provide a 2-year analytics strategy aligned with facility's strategic growth plan, and then report their findings to the state office. The top 100 health systems definitely have an advantage due to the extra money they have analyze their data.

Of four facilities studied only one had an analytic resource. The recommendations were:

- Increase data integration and data sharing.
- Elevate programs that demonstrate how to take action with data within current provider stewardship.
- Augment programs that use data to make care more accessible and effective.
- Educate administrators on data security and analytics capabilities.

Chris Klomp asked how they felt about efforts to help form policy to help these efforts. John said that there were a lot of good efforts with STEM type education. What is important is to get people excited about STEM related education and careers. What is important is to lobby for use case programs and create internships including for high school students. Such efforts could help students see things they could do in the medical field other than being a nurse or doctor.

Preston Adjourned the meeting